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# THE USE OF PSYCHOTHERAPY TREATMENT MANUALS: A SMALL REVOLUTION IN PSYCHOTHERAPY RESEARCH STYLE

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**Abstract.** *In the space of just the last few years it has become a virtual research requirement to incorporate manuals in comparative psychotherapy studies. Such manuals serve to guide the training of the therapists and then the measurement of their conformity to the intended treatments. A short history of this small revolution is provided. It is followed by a review of the findings of comparative treatment studies which were manual guided versus nonmanual guided. While many of the expected differences among conceptually different treatments appear with both approaches, with manual guided studies it tends to be easier to do exact comparisons. A study comparing manual guided versus nonmanual guided treatments should be the logical next step.*

Recommendations to psychotherapists on how to conduct psychotherapy are plentiful, and can usually be found in the form of books written about one approach or another. However, only since 1976 have formal psychotherapy manuals emerged as important guides for researchers, teachers and practitioners. Manuals are differentiated from other writings about a psychotherapy in that they provide more explicit guidelines for the therapist to follow in the conduct of the therapy, and focus on the specific techniques and strategies that are acceptable and desirable in the therapy. Manuals for various psychotherapeutic approaches have now been developed; they are meant to serve several purposes:

1. *To aid in objective comparisons of psychotherapies in research studies.* The descriptions in the manual can serve as a basis for developing measurement systems that can be applied to observations of patient-therapist interactions. These ratings can reveal the ways in which psychotherapies are distinct from each other, as well as areas of overlap among therapeutic approaches (see DeRubeis, Hollon, Evans, & Bemis, 1982; Luborsky, Woody, McLellan, O'Brien, & Rozenzweig, 1982, or summaries of the findings of these investigations below).

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2. *To aid in the measurement of the degree to which a given therapist provided what is intended in a given approach.* Rating scales developed from the manuals can be used to estimate the degree to which the intended form of psychotherapy described in the manual was actually provided; that is, the degree of conformity by each therapist to the intended form of treatment as described in the manual. Results on one version of conformity, the "purity" of a set of techniques, have been reported (Luborsky, McLellan, Woody, & O'Brien, 1983). Purity in this study was defined as the ratio of the use of the treatment techniques in the therapists' own manual over the use of all techniques (all techniques include those in other manuals as well as those in own manual). This measure of purity was highly correlated with the therapists' success rate with patients. Investigations are currently under way to discover the degree to which a therapist's conformity to the specifications of a manual predicts the outcomes of cognitive therapy (Hollon, DeRubeis, & Evans, 1983).

If further studies of relationships between such conformity measures and outcome are consistent with the findings of Luborsky et al. (1983), there would be at least three possible explanations for the results. These assessments might reflect(a) more general abilities in the therapist that produce maximal change in patients, (b) the degree to which "good" patients (who have good outcomes) allow or encourage therapists to follow the recipe in the manual (see Rounsaville, Weissman, & Prusoff, 1981), or (c) a causal relationship between the "amount" of the intended form of therapy delivered and the resulting therapeutic effect. Clearly, this latter possibility is the most theoretically interesting one. If such a causal relationship were to be found, it would be analogous to the relationships between dosage and treatment response that have been found for various psychotropic medications.

A related use of rating scales that are derived from manuals is in the comparison of therapy conducted across different studies. Discrepancies between outcomes produced by the same manual-based therapy in two different studies could be investigated by comparing the performance of the therapists on manual-based rating scales. If the more effective manifestation of the therapy is accompanied by higher ratings on the rating scales, one plausible explanation for the discrepancy would be identified.

3. *To aid in the training of therapists.* Since the treatment manuals specify the main techniques of a psychotherapy, they can provide guidelines for training psychotherapists, both for clinical practice and for participation in research studies. Furthermore, the actual utility of the manuals in training can itself be investigated by scoring samples of the psychotherapy to assess the degree to which conformity with an approach increases with training in its use.

## THE SHORT HISTORY OF PSYCHOTHERAPY MANUALS

One impetus to develop manuals came from the recent assumption by psychotherapy researchers that good research designs require them, especially for studies which compare the relative effectiveness of different forms of psychotherapy. Concern regarding certain methodological issues increased, and one of the often heard recommendations was for the use of more systematic treatment manuals to guide the conduct of psychotherapies tested in outcome studies. Aside from the researchers themselves, other groups also felt that the time had come for bigger and better comparisons of the effectiveness of psychotherapies. The advocates of psychotherapy research included third-party insurance payers, some congressional com-

mittees during the Carter administration, Gerald Klerman (then director of ADAMHA), and many research psychologists and psychiatrists. The sentiment was that, as a society, we should bring to bear on psychotherapy the research tools and rigor that had been successfully employed in pharmacological research. Specifically, there came a desire to do research that would allow for the calibration of treatment amount and quality, and for the assessment of the effectiveness of various treatments.

For about 40 years the field had seen a steady stream of small studies which assessed the effectiveness of various psychotherapies (see Luborsky, Singer, & Luborsky, 1975; Smith, Glass, & Miller, 1980, for reviews). This type of research was now slated to receive a new infusion of enthusiasm and money. It was not simply a renewal of interest on the part of psychotherapy researchers, but an idea which intrigued many individuals from many sectors. As reported in the APA Monitor, June, 1980, "...Senate Finance Health Subcommittee staff have been working with administration offices and professional groups, including the American Psychological Association and the American Psychiatric Association, in an effort to come up with a bill redefining eligible health providers under Medicare and Medicaid and to establish clinical trials of psychotherapy" (p. 1). Even following the funding cuts of the Reagan administration, the research direction appears to have been maintained, albeit without the earlier momentum.

The earliest treatment manuals were designed for the behavior therapies (e.g., Wolpe, 1969). Researchers in the field of behavior therapy could have been expected to introduce manuals into their work before others for several reasons. Some of the fundamental qualities of the behavior therapies that distinguish them from other approaches are the same qualities that would lead to the desire to formalize treatment in a manual. The specification of therapist behavior that is involved in writing or following a manual is similar to the specification of patient behavior that is involved in the conduct of behavior therapy. Also, behavioral therapies are often sets of procedures that are to be applied in a relatively systematic fashion. Such procedural specification fits perfectly with the main function of a treatment manual: to outline the procedures, techniques and strategies which comprise an acceptable implementation of a given approach.

Manuals for nonbehavioral therapies are more recent phenomena, but their numbers have increased rapidly over the past several years. The less prescriptive is a treatment approach, the less it lends itself to specification in the form of a manual, and the more the manual writer must allow for flexibility of approach by the therapist. The nonbehavioral therapies, being less prescriptive, have provided a challenge to manual writers. However, several manuals for the psychotherapies are now completed, although only one has been published thus far (Beck, Rush, Shaw, & Emery, 1979). Those written for psychotherapy include manuals for (a) supportive-expressive psychoanalytically oriented psychotherapy (Luborsky, 1976; Luborsky, 1984) and an adaptation for drug abuse patients (Luborsky, Woody, Hole, & Velleco, 1977); (b) cognitive therapy of depression (Beck et al., 1979); (c) interpersonal psychotherapy of depression (Klerman & Neu, 1976; Klerman, Rounsaville, Chevron, Neu, & Weissman, 1979; Klerman, Weissman, Rounsaville, & Chevron, in press); (d) nonscheduled minimal treatment controls (Luborsky & Auerbach, 1979, as adapted from DiMascio, Klerman, Weissman, Prusoff, Neu, & Moore, 1979); and (e) short-term dynamic psychotherapy (Strupp & Binder, 1982). A manual has also been developed (Fawcett & Epstein, 1982) for the clinical management of depressed patients who are being treated with pharmacotherpay

in the Depression Collaborative Study (Waskow, Hadley, Parloff, & Autry, in preparation). Currently in preparation is a compendium of six treatment manuals for drug-dependent patients, together with evidence for the efficacy of each treatment (Woody, Luborsky, & McLellan, 1983).

As further evidence of the popularity of manuals, the American Psychiatric Association has appointed a commission on psychiatric therapies (APA Commission, 1982) which is attempting to develop a "psychiatric treatment manual." This ambitious project is an effort to define the characteristics of all of the psychiatric treatments, to identify their therapeutic effectiveness, and to identify the types of patients for whom each is best suited.

The treatment manuals mentioned above have been used in studies completed and in progress (e.g., Neu, Prusoff, & Klerman, 1978; Weissman, 1979). By far the largest and best known of the studies in which manuals are employed is the Depression Collaborative Study (Waskow et al., in preparation). Although the study is still in its middle stages, it has already had an enormous impact. It has firmly established the pattern for comparative studies of psychological treatments to incorporate treatment manuals in their designs.

### *Research Findings Based on Content Analyses of Non-Manual-Based Psychotherapies*

Although the ability of clinicians to identify the manual-based therapies has only recently been studied, non-manual-based psychotherapies have been examined for more than three decades. In the early 1950's, Fiedler (1950a; 1950b; 1951) found that experienced psychoanalytic, nondirective, and Adlerian therapists were more similar to one another than they were to inexperienced therapists in their own respective schools. The similarity lay in the manner in which the therapists established relationships in therapy. However, many studies have shown that distinctions among treatments can be observed, and that these distinctions are generally consistent with what would be expected, given the theories which underlie the therapies under comparison. For example, Strupp (1958) showed that therapists in client-centered psychotherapy (Rogers, 1957) relied primarily on summarizing the patient's feelings, whereas the therapists in short-term analytic therapy (Wolberg, 1967) more frequently relied on more highly inferential interpretations of the material obtained from the patient. Auerbach (1963) found that therapists who used Wolberg's (1967) short-term approach used fewer interpretations, provided less direct guidance, and were less inferential than therapists who used Wittaker and Malone's (1961) experiential therapy. Brunink and Schroeder (1979) found that Gestalt and behavior therapists exhibited approximately equal levels of empathy, but they displayed differences in the use of direct guidance, facilitative techniques, therapist self-disclosure, therapist initiative, and supportive climate.

In a widely cited comparison of psychoanalytically oriented psychotherapy and behavior therapy, Sloane, Staples, Cristol, Yorkson and Whipple (1975) reported that the behavior therapists were more active than the psychotherapists; they took up a higher proportion of the session with their speech and made more information-providing statements. Unexpectedly, however, there were no differences between the two types of therapists in their use of interpretive and clarifying statements, perhaps because these were lumped together in one category. Whether a more detailed analysis of the types of interpretations and clarifications made by the therapists would have differentiated the two groups cannot be inferred from their

data. Nevertheless, the results of speech content and pattern analysis from the Sloane et al. (1975) study, as well as other studies, have shown that observed differences between therapies are generally consistent with the differences that would be expected on the basis of the respective theories.

### *Research Findings Based Upon the Use of Manual-Based Psychotherapies*

Although findings from studies which have not employed manuals have often found that psychotherapies can be meaningfully differentiated, it is reasonable to expect that manual-based therapies might yield even clearer results of this kind. Sharper distinctions would be anticipated, and the nature of the differences might be even more consistent with what is expected from the psychotherapies compared. One of the earliest studies which examined the use of techniques in a manual-based therapy was conducted by Neu et al. (1978). The aim was to categorize the behavior of therapists who had been trained to follow Klerman and Neu's (1976) interpersonal therapy (IPT) manual. Neu et al. found that the therapists used (a) non-judgemental exploration 45% of the time across all sessions, (b) elicitation 21% of the time, (c) clarification 14% of the time, and (d) direct advice 7% of the time. These percentages were generally in accord with what was expected from IPT therapists.

Luborsky et al. (1982) reported results from two studies in which they evaluated the ability of clinical judges to recognize samples of each of three manual-based therapies. Transcripts to be judged were derived from sessions conducted in the Woody, McLellan, Luborsky and O'Brien (1981) study of the treatment of substance abuse patients. The three therapies were: (a) drug counseling (DC; Woody, Stockdale, & Hargrove, 1977), (b) supportive-expressive psychoanalytically-oriented psychotherapy (SE; Luborsky, 1976), and (c) cognitive-behavioral psychotherapy (CB; Beck & Emery, 1977). Two clinical judges made ratings independently from one another on three or four specific criteria for each type of therapy, and on global scales which assesssed the degree to which the session fit the specifications of each treatment manual. The ratings were made from 15-minute samples of therapy. A separate judge made frequency counts of specific speech content categories (as in the Sloane et al., 1975 study).

Several clear results emerged from analyses of these ratings. They will be described in turn (from Luborsky et al., 1982).

1. Judges were able to discriminate the three types of therapies from one another at well above a chance level. Chance performance would have yielded 33% correct classifications, yet the judges made the correct classification 73% of the time in study 1, and 80% of the time in study 2.

2. The two judges gave the same designation to a given sample of therapy in 67% of the cases, where 33% agreement would have been expected by chance.

3. On average, each treatment was rated as fitting the specifications of its manual to a greater degree than was either of the other treatments. For example, the mean rating for SE on "the degree to which the treatment fits the specifications of SE psychotherapy" was 2.8 on a scale of one to five. Ratings on this scale were 1.9 and 1.5, respectively, for CB and DC. The ratings for the SE sessions were greater than for the other two at the .01 significance level.

4. Certain specific techniques also clearly distinguished the treatments. The SE sessions were judged to be significantly more focused on "the understanding of the relationship with the patient, including transference" than were sessions of the

other therapies. Similarly, SE sessions were judged to have a greater degree of "focus on facilitating self-expression as part of the search for understanding." "Directiveness" was the most distinctive component of CB, followed by "finding cognitive distortions" and "challenging cognitive beliefs". Most distinctive of DC was the therapists' "monitoring current problems" as well as "giving advice."

5. Ratings of some of the qualities recommended in the respective manuals did not differentiate the treatments. For example, "giving support" was rated as having occurred at a moderate level in all three treatments. Although this quality has a prominent place in the SE manual, it is not emphasized in the manuals for CB and DC. Therefore it seems justified to conclude that what is presented in a manual may not be exhaustive of the qualities that are displayed by representatives of a given therapeutic approach. Furthermore, qualities not explicitly described in a manual may turn out to be those qualities that are most crucial to the success of the therapy.

6. Several content categories of therapist speech, using the Temple Content Category Method (Sloane et al., 1975) showed significant differences among treatments. For example, "therapists' percentage of time speaking" was 14% for SE, 36% for CB, and 29% for DC (all different from one another at the .01 level). When the SE therapists did speak, their comments were considerably more "nondirective" (62% for SE, 25% for CB, and 36% for DC, all different from each other at the .01 level). When just three of the therapist content categories were taken together, a discriminant function analysis separated tapes from the three modalities to a remarkable degree. The three categories were "the percent nondirective statements," "the percent clarification statements," and "the percent disapproval." A discriminant function yielded correct classification of 100% of the CB tapes, 95% of the SE tapes, and 91% of the DC tapes. It should be noted that although these categories are not explicitly stipulated by the manuals, the results are consistent with what would be expected from an understanding of the respective manuals. For example, although the SE manual does not explicitly instruct the SE therapist to minimize speaking, it is clear from the approach described in the manual that SE therapists would be expected to speak less than would CB or DC therapists.

Another perspective can be achieved by examining the profiles of the types of therapist statements and comparing the profiles across treatments and across studies. Table 1 presents data from the Penn-V.A. study (Woody et al., 1981), the Yale study (Weissman, Prusoff, DiMascio, Neu, Goklaney, & Klerman, 1979), and the Temple study (Sloane, et al., 1975). By inspection it is clear that the most distinctive profile among those compared is that of the DC therapists. IPT tends to fall between the SE and CB profiles. Also note that the psychoanalytic psychotherapy represented in the Temple study has much in common with the SE of the Penn-V.A. study, as would be expected. The use of profiles may prove to be helpful in further efforts to compare and contrast psychotherapies on the basis of rated behavior.

In another recent study, DeRubeis et al. (1982) investigated the similarities and differences in the rated behavior of therapists using CB or IPT in the treatment of depressed patients. Both treatments are based on manuals (Beck et al., 1979 for CB; Klerman et al., 1979 for IPT). A 48-item rating scale was developed for the study and was implemented by twelve raters, each of whom watched or listened to four sessions of therapy, two from each school. Six videotaped sessions of each form of therapy served as the observation samples, and each session was rated on all 48 items by four different observers.

**TABLE 1. Content Analysis of Psychotherapy: Percentage of Each Type of Therapist Statement[a] (*n* = number of tapes)**

| | Penn-VA Study[b] | | | Yale Study | Temple Study | |
|---|---|---|---|---|---|---|
| Content Category | DC ($n=35$) | SE ($n=27$) | CB ($n=21$) | IPT[c] ($1=9$) | "SE"[d] ($1=30$) | B[e] ($n=30$) |
| Average % Time Speaking | 29.1 | 14.4 | 35.5 | 26.5 | — | — |
| Average % Asking For Information Statements | 27.1 | 17.2 | 39.5 | 18.4 | 32.0 | 32.0 |
| Average % Giving Information Statements | 17.4 | 2.6 | 3.5 | 1.6 | 3.0 | 7.0 |
| Average % Clarification and Interpretation Statements | 8.2 | 13.0 | 21.3 | 20.9 | 26.0 | 32.0 |
| Average % Non-Directive Statements | 35.6 | 62.3 | 24.9 | 47.1 | 44.0 | 26.0 |
| Average % Directive | 4.2* | 1.7 | 5.8 | 5.9 | 2.0 | 8.0 |
| Average % Approval Statements | 3.4 | 2.4 | 3.6 | 1.7 | 1.0 | 2.0 |
| Average % Disapproval Statements | 4.1 | 0.7 | 1.4 | 4.3 | .5 | 1.0 |

*Groups underlined are not significantly different within the Penn-VA study.

[a] These percentages add up to 100 when percentage time speaking is excluded. The Temple study percentages are not exact since they were read off of a graph (Sloane et al., 1975, Figure 25, p. 159).

[b] The Penn-VA study "DC" was drug counseling, "SE" was the supportive-expressive psychotherapy in this manual and the "CB" was cognitive-behavioral psychotherapy.

[c] The Yale study "IPT" was "Interpersonal Psychotherapy"

[d] The Temple study "SE" was designated psychoanalytically-oriented psychotherapy (Sloane et al., 1975)

[e] The Temple study "B" was "Behavior therapy"

Of the 48 items, 34 discriminated between the two types of therapy at the .05 level. Experts in each of the two approaches rated the items as they would (hypothetically) after viewing a "good, typical CB (or IPT) session." Based on these expert judgements, differentiation between the two therapies was expected for 24 of the items, and differences were observed on 22 of those, all in the expected direction. However, 12 of the 24 items which were not expected (by the experts) to differentiate the therapies did, indeed, separate CB and IPT sessions. Thus, the therapies were differentiated in almost every case in which differences were expected, as well as in many cases for which differences were not expected.

A factor analysis of the entire item pool revealed that four interpretable factors could be derived from the observations of the videotapes. Factor I was named CB Technique, Factor II was named General Therapeutic Skills, Factor III was named

Therapist Directiveness, and Factor IV was named IPT Technique. Large differences between the two therapies were expected by the experts on Factors I, III, and IV. Observed scores for the two therapies were in fact well differentiated by each of these factors, in the expected direction in each instance. In addition, the mean rating of each therapy on each of these three factors closely mirrored the experts' expected ratings. Factor II, General Therapeutic Skills, was not expected to clearly differentiate the two approaches, but for the sample of tapes under study, raters rated the CB sessions as being higher on this dimension. However, it must be noted that the IPT in this study was carried out by therapists in training.

A discriminant function analysis yielded perfect classification of the tapes into the two respective categories, suggesting that, indeed, these two samples of manual-based therapies were distinct from one another.

To summarize, therapists in CB and IPT, both of which are targeted at the reduction of depressive symptomatology, but by presumably different means, were found to be different in expected ways.

More refined scales are currently being developed, under a contract from NIMH (#278–81–0031(ER)—to the University of Minnesota), to tap the major dimensions of CB and IPT. This effort involves a much larger sample of tapes (from the NIMH Treatment of Depression Collaborative Research Program) and improved rating methods (see Hollon, Tuason, Wiemer, & DeRubeis, 1981).

## SUMMARY AND DISCUSSION

The use of therapy manuals in training and in research has been discussed, as well as some of the research methods that naturally flow from the introduction of manuals into psychotherapy research. The extensive description of a treatment that is embodied in a manual provides far more information than does the single phrase that often described psychotherapy in research reports up until the last few years. Thus, researchers can now communicate much more precisely the nature of the treatment(s) in a given study.

With the emphasis that has been placed on the use of manuals in research has come a vigorous interest in the measurement of the behaviors that correspond to the various treatments. When manuals are employed, and therapist behavior is assessed for compliance with the manual, even more precise knowledge can be made available concerning the procedures actually employed in a given study. As was discussed in more detail above, the resultant measures of therapists' behavior may be put to many interesting and practical uses.

Consistency has been observed between therapist behaviors and procedures outlined in the respective manuals in the three studies cited above. Whether the conformity was due to the fact that the therapies in these studies were manual-guided is an open question. The answer to the question of whether manual-based therapies are more distinctive than non-manual-based therapies awaits a study which directly compares therapies which differ on this variable.

Given the apparent advantages for the training and monitoring of therapists in the context of research studies, and the advantages for the communication of procedures used in research, it is recommended that future investigations of the effectiveness or nature of psychotherapies include, at minimum, the use of a manual that describes the intended therapeutic procedures. Such a requirement is already in place for the publication of outcome studies in at least one journal (*Cognitive Therapy and Research*; see instructions to contributors, April, 1983). It is further

recommended that, whenever possible, the actual treatment delivered in the context of a research study be monitored and assessed for its convergence with the procedures in the manual. What is here recommended for psychotherapy research is simply sound experimental practice: to specify the treatment procedures recommended (the independent variables) and to conduct a check on the treatment manipulations employed.

## REFERENCES


American Psychiatric Association Commission on Psychiatric Therapies (T. Karasu, chair). Unpublished manuscript, Washington, D.C., 1982.

Auerbach, A. H. An application of Strupp's method of content analysis of psychotherapy. *Psychiatry*, 1963, **26**, 137–148.

Beck, A. T., & Emery, G. D. *Individual treatment manual for cognitive behavioral psychotherapy for drug abuse.* Unpublished manuscript, University of Pennsylvania, 1977.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. D. *Cognitive therapy of depression: A treatment manual.* New York: Guilford Press, 1979.

Brunink, S., & Schroeder, H. Verbal therapeutic behavior of expert psychoanalytically oriented, Gestalt, and behavior therapists. *Journal of Consulting and Clinical Psychology*, 1979, **47**, 567–574.

DeRubeis, R. J., Hollon, S. D., Evans, M. D., & Bemis, K. M. Can psychotherapies for depression be discriminated? A systematic investigation of cognitive therapy and interpersonal therapy. *Journal of Consulting and Clinical Psychology*, 1982, **50**, 744–756.

DiMascio, A., Klerman, G., Weissman, M., Prusoff, B., Neu, C. & Moore, P. A control group for psychotherapy research in acute depression: One solution to ethical and methodological issues. *Journal of Psychiatric Research*, 1979, **15**, 189–197.

Fawcett, J., & Epstein, P. *Clinical management—imipramine—placebo administration manual.* Unpublished manuscript, Rush Presbyterian St. Luke's Medical Center, 1982.

Fiedler, F. E. The concept of the ideal therapeutic relationship. *Journal of Consulting Psychology*, 1950, **14**, 239–245. (a)

Fiedler, F. E. A comparison of therapeutic relationships in psychoanalytic, non-directive, and Adlerian therapy. *Journal of Consulting Psychology*, 1950, **14**, 436–445. (b)

Fiedler, F. E. Factor analysis of psychoanalytic, non-directive, and Adlerian therapeutic relationships. *Journal of Consulting Psychology*, 1951, **15**, 32–38.

Hollon, S. D., DeRubeis, R. J., & Evans, M. D. *A model for studying the change process in treatment outcome research.* Manuscript in preparation, University of Minnesota, 1983.

Hollon, S. D. Tuason, V. B., Wiemer, M. W., & DeRubeis, R. J. *System for rating psychotherapy audiotapes* (National Institute of Mental Health Application for Contract #278–81–0031). University of Minnesota and the St. Paul-Ramsey Medical Center, 1981.

Klerman, G., & Neu, C. *A manual for interpersonal treatment of depression.* Unpublished manuscript, Yale University, 1976.

Klerman, G., Rounsaville, B., Chevron, E., Neu, C., & Weissman, M. *Manual for short-term interpersonal psychotherapy (IPT) for depression.* Unpublished manuscript, Yale University, 1979.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. *The theory and practice of interpersonal psychotherapy for depression.* New York: Basic Books, in press.

Luborsky, L. *A general manual for supportive-expressive psychoanalytically oriented psychotherapy.* Unpublished manuscript, University of Pennsylvania, 1976.

Luborsky, L. *Principles of psychoanalytic psychotherapy—A manual for supportive-expressive treatment (SE)* New York: Basic Books, in press.

Luborsky, L., & Auerbach, A. H. *Manual for nonscheduled minimal treatment.* Unpublished manuscript, University of Pennsylvania, 1979.

Luborsky, L., McLellan, A. T., Woody, G., & O'Brien, C. *Therapist success rates and their determinants.* Paper presented at the Society for Psychotherapy Research, Sheffield, England, July, 1983.

Luborsky, L., Singer, B. & Luborsky, L. Comparative studies of psychotherapies: Is it true that "Everybody has won and all must have prizes?" *Archives of General Psychiatry*, 1975, **32**, 995–1008.

Luborsky, L., Woody, G., Hole, A., & Velleco, A. *Treatment manual for supportive-expressive psychoanalytically oriented psychotherapy—Special adaptation for treatment of drug dependence.* Unpublished manuscript, University of Pennsylvania, 1977.

Luborsky, L., Woody, McLellan, A. T., O'Brien, C. P., & Rosenzweig, J. Can independent judges recognize different psychotherapies? An experience with manual-guided therapies. *Journal of Consulting and Clinical Psychology*, 1982, **50**, 49–62.

Neu, C., Prusoff, B., & Klerman, G. Measuring the interventions used in the short-term psychotherapy of depression. *American Journal of Orthopsychiatry*, 1978, **48**, 629–636.

Rogers, C. The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 1957, **21**, 95–103.

Rounsaville, B. J., Weissman, M. M., & Prusoff, B. A. Psychotherapy with depressed outpatients: Patient and process variables as predictors of outcome. *British Journal of Psychiatry*, 1981, **138**, 67–74.

Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkson, N. J., & Whipple, K. *Psychotherapy versus behavior therapy*. Cambridge, Mass.: Harvard University Press, 1975.

Smith, M., Glass, G., & Miller, T. *The benefits of psychotherapy*. Baltimore: Johns Hopkins Press, 1980.

Strupp, H. The performance of psychoanalytic and client-centered therapists in an initial interview *Journal of Consulting Psychology*, 1958, **22**, 265–274.

Strupp, H., & Binder, J. *Time-limited psychotherapy (TLDP): A treatment manual* Unpublished manuscript, Vanderbilt University, 1982.

Waskow, I. E., Hadley, S. W., Parloff, M. B., & Autrey, J. H. *Psychotherapy of depression collaborative research program*. Clinical research Branch, National Institute of Mental Health, Rockville, Md., in preparation.

Weissman, M. M. The psychological treatment of depression: Evidence for the efficacy of psychotherapy alone, in comparison with, and in combination with pharmacotherapy. *Archives of General Psychiatry*, 1979, **36**, 1261–1269.

Weissman, M. M., Prusoff, B. A., DiMascio, A., Neu, C., Goklaney, M., & Klerman, G L. The efficacy of drugs and psychotherapy in the treatment of acute depressive episodes. *America Journal of Psychiatry*, 1979, **136**, 555–558.

Wittaker, C. & Malone, T. Rational and nonrational psychotherapy. A reply. *American Journal of Psychotherapy*, 1961, **15**, 212–220.

Wolberg, L. R. *The techniques of psychotherapy* (2nd ed.). New York. Grune & Stratton, 1967.

Wolpe, J. *The practice of behavior therapy*. New York: Pergamon, 1969.

Woody, G. E., Luborsky, L., & McLellan, T. *Psychological treatment manuals for drug abuse patients and evidence for their effectiveness*. Unpublished manuscript, University of Pennsylvania, 1983.

Woody, G. E., McLellan, A. T., Luborsky, L., & O'Brien, C. P. Psychotherapy for opiate addiction: Some preliminary results. *Annals of the New York Academy of Sciences*, 1981, **362**, 91–100.

Woody, G. E., Stockdale, D., & Hargrove, E. *A manual for drug counseling* Unpublished manuscript, University of Pennsylvania, 1977.